Strategic Framework for Modernizing the Kansas Behavioral Health System

Working Groups Report to the Special Committee on Mental Health Modernization and Reform

[*Note:* **Updated** to reflect recommendations approved by the Special Committee at its meetings on December 10-11, 2020.]

December 9, 2020

Figure 3. **Select Measures to Assess the Kansas Behavioral Health System**

PROCESS MEASURE				
Measure:	**Number**		**Percent**	
Kansas counties recognized as a Mental Health Professional Shortage Area. *Lower number/percentage of counties is better.*	99 (2019)		94.3% (2019)	
Counties served by Mobile Response and Stabilization Services. *Higher number/percentage of counties is better.*	*		*	
Counties served by Crisis Intervention Centers. *Higher number/percentage of counties is better.*	*		*	
OUTCOME MEASURES				
Measure:	**Kansas current (year)**	**Kansas previous (year)**	**U.S. current (year)**	**U.S. previous (year)**
Uninsured rate (adults age 19-64). *Lower rates are better.*	13.1% (2019)	12.6% (2018)	12.9% (2019)	12.5% (2018)
Uninsured rate (children age 0-18). *Lower rates are better.*	5.8% (2019)	5.1% (2018)	5.7% (2019)	5.2% (2018)
Statewide age-adjusted mortality rate for suicide per 100,000 population. *Lower rates are better.*	19.9% (2017)	19.2% (2016)	15.2% (2017)	14.7% (2016)
Percent of high school students who report feeling sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities (i.e., criteria for and predictors of clinical depression). *Lower percentage is better.*	32.5% (2019)	24.8% (2017)	36.7% (2019)	31.5% (2017)
Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling. *Higher percentage is better.*	55.9% (2018-2019)	52.7% (2017-2018	53.2% (2018-2019)	52.7% (2017-2018)
Individuals with SPMI that have been enrolled in supportive housing and have not had an ER or Psychiatric Hospital admission in the last 12 months. *Higher percentage is better.*	*	*	NA	NA

Figure 3 (continued). **Select Measures to Assess the Kansas Behavioral Health System**

OUTCOME MEASURES (continued)				
Measure:	**Kansas current (year)**	**Kansas previous (year)**	**U.S. current (year)**	**U.S. previous (year)**
Individuals with SPMI that have been enrolled in supportive employment and have not had an ER or Psychiatric Hospital admission in the last 12 months. *Higher percentage is better.*	*	*	NA	NA
Percent of individuals with an inpatient psychiatric stay in the previous year, that have returned to and remain in the community without additional hospitalizations. *Higher percentage is better.*	**	**	NA	NA

MENTAL HEALTH in AMERICA RANKINGS of 50 states and Washington D.C. by report year							
Select Measure: *States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes.*	**2021**	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
Kansas rankings: overall.	#29	#42	#24	#19	#21	#15	#19
Kansas ranking: Adult (prevalence and access to care).	#38	#43	#28	#22	#23	#16	#23
Kansas ranking: Youth (prevalence and access to care).	#26	#37	#21	#19	#18	#15	#8
Kansas ranking: Adults with mental illness who report unmet needs.	#51	#46	#29	#39	#38	#28	#51
Kansas ranking: Youth with at least one major depressive episode who did not receive mental health services.	#18	#47	#40	#29	#12	#12	NA

Note: The asterisk (*) indicates that data are reportable by a state agency. The double-asterisk (**) means that the measure could be reported in the future, assuming implementation of certain recommendations related to data interoperability and higher rates of participation in health information exchanges. NA stands for not available.

The Mental Health in America overall ranking uses national data from surveys including the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS). The overall ranking is comprised of 15 measures for adults and youth around mental health issues, substance use issues, access to insurance, access to adequate insurance, as well as access to and barriers to accessing mental health care. A rank of 1-13 indicates lower prevalence of mental illness and higher rates of access to care, and an overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. Data in each reporting year come from previous reporting periods. For example, in the 2021 report, most indicators reflect data from 2017-2018, while the 2020 report includes data from 2016-2017 and so forth. The baseline report year is 2015. For more information, go to https://www.mhanational.org/issues/2021/ranking-guidelines.

Source: Data as reported by the Kansas Department for Aging and Disability Services (KDADS), Kansas Department of Health and Environment (KDHE), Kansas Department of Corrections (KDOC), Kansas State Department of Education (KSDE) and KHI analysis of data from the U.S. Census Bureau 2018-2019 American Community Survey Public Use Microdata Sample files for uninsured rates and 2015-2021 Mental Health in America Rankings.

[*Note:* In above fields were data is absent and denoted with an asterisk (* or **), the Committee requests the reporting agency or entity submit data as it becomes available or upon program changes.]

Workforce Recommendation 1.1: **Clinical Supervision Hours [Immediate Action]**

Recommendation: Where applicable, reduce the number of clinical supervision hours required of master's-level behavioral health clinicians to obtain clinical licensure from 4,000 to 3,000, similar to the reduction in clinical hours of social workers.	
Rationale: A version of this recommendation was originally developed by the Committee on Alcohol and Other Drug Abuse of the Governor's Behavioral Health Services Planning Council.[1] A similar change was made for social workers in 2019 and has made recruitment of social workers easier in some parts of the state. BSRB intends to support legislation that would enact this change in the 2021 Legislative Session. This change would bring Kansas licensing requirements in alignment with neighboring states.	
Ease of Implementation *(Score 1-10):* 8	**Potential for High Impact** *(Score 1-10):* 8
• Would require a program change and change in legislation. • Cost is not a barrier to implementation.	• Would impact the entire state. • Could lead to a reduction in workforce inequities by geography, particularly in rural and frontier counties.
Measuring Impact: Percent or number of master's-level behavioral health clinicians practicing in Kansas.	
Action Lead: BSRB	**Key Collaborators:** Legislature, KDADS

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Workforce Recommendation 1.2: **Access to Psychiatry Services [Immediate Action]**

Recommendation: Require a study be conducted by KDHE with an educational institution, to explore strategies to increase the number of psychiatrists, child and adolescent psychiatrists, and psychiatric nurses. [*Note:* The Committee requests consideration be given to educational institutions, regardless of size, that can provide this expertise and assistance.]	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force.[2] Multiple areas in the state are struggling to recruit and retain psychiatrists and psychiatric nurses, with an additional 54 psychiatrists needed to eliminate the Mental Health Care Health Professional Shortage Areas (HPSAs) in Kansas.[3] An important next step once the study is completed would be exploring implementation of the strategies outlined in the report.	
Ease of Implementation *(Score 1-10): 9*	**Potential for High Impact** *(Score 1-10): 8*
• Would be relatively easy to implement once funding is available.	• Implementing strategies from the report could impact frontier and rural communities that struggle to recruit psychiatric providers.
Measuring Impact: • Percent or number of mental health care professionals participating in the Kansas State Loan Repayment Program. • Number of Kansas counties recognized as a Mental Health Professional Shortage Area. • Number of adult and child/adolescent psychiatry residents in Kansas.	
Action Lead: KDHE	**Key Collaborators:** Educational institution

Workforce Recommendation 1.5: **Family Engagement Practices [Strategic Importance]**

Recommendation: Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families.	
Rationale: A version of this recommendation was originally developed by the Children's Subcommittee of the Governor's Behavioral Health Services Planning Council.[7] Parent and family engagement practices can create shared responsibility between providers and families, such as by involving families in decision making. It can lead to improved clinical outcomes, as well as improved educational outcomes and health behaviors when parents and families are engaged by schools.	
Ease of Implementation *(Score 1-10): 5*	**Potential for High Impact** *(Score 1-10): 8*
• Cost could be a barrier to implementation. • Could require changes in a legislative session and agency budget development.	• High impact for pediatric behavioral health population.
Measuring Impact: • Number of families served. • Percent of children and parents whose functionality scores improved (over set time period). • Rate of provider turnover.	
Action Lead: KDADS	**Key Collaborators:** KDHE, Legislature

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Funding and Accessibility

In a modernized behavioral health system, the State will need to proactively pursue new funding mechanisms, including alternative models such as the Certified Community Behavioral Health Clinic (CCBHC) model, to ensure that reimbursement rates are competitive. The State has the expertise, research and recommendations in place to support changes to how behavioral health is funded in Kansas, and implementation should be pursued across administrations.

The Working Group asserted that accurate and appropriate funding ~~**of**~~ **for all** **Kansans** ~~**who currently lack coverage**~~ is a key element of a sustainably funded, modern behavioral health system, and a modernized system will successfully identify the right populations to serve and make services meaningfully accessible. Likewise, a modernized system should rely on measurable outcomes to drive decisions. Key challenges related to funding and accessibility requirements for budget neutrality on the 1115 Medicaid Waiver, limited availability of SUD block grant dollars, and low reimbursement rates at community mental health centers and for SUD providers.

Funding and Accessibility Recommendation 2.3: **Reimbursement Rate Increase and Review [Immediate Action]**

Recommendation: Implement an immediate increase of 10-15 percent for reimbursement rates for behavioral health services. After increasing reimbursement rates, establish a Working Group to regularly review the reimbursement structures for behavioral health services for both the uninsured and the Medicaid population.	
Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).[10] The MHTF recommendation included a detailed review of reimbursement rates and recommended rates be updated accordingly. Working Group members, however, felt that a pressing need was an overall increase to reimbursement rates for behavioral health services in order to maintain the Community Mental Health Center (CMHC) system in the state. In discussion, Working Group members highlighted that few changes to reimbursement rates had occurred in the last 20 years and were overdue. Once reimbursement rates are increased, Working Group members recommend having a task force review the behavioral health reimbursement structure of both the uninsured and Medicaid populations to ensure long-term sustainability. In the 2020 Legislative Session, the final budget bill included a proviso requiring KDHE to complete a detailed review of costs and reimbursement rates for behavioral health services in the state.[11] This review is due in January 2021 and may include information to be reviewed by a Working Group or task force.	
Ease of Implementation *(Score 1-10): 6*	**Potential for High Impact** *(Score 1-10): 8*
• Cost will be a barrier to implementation.	• Would impact a large population.
Measuring Impact: • Frequency of reimbursement rate updates	
Action Lead: Legislature	**Key Collaborators:** KDADS, KDHE, CMHCs

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[*Note:* Does the Committee wish to include information presented by the State Medicaid Director regarding the top 6 behavioral codes by utilization and claims.]

Prevention and Education Recommendation 4.2: **Early Intervention [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment and treatment.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force, and action steps that could support this recommendation can be found in Recommendation 3.4 of the Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.[21]

Early identification of behavioral health symptoms can allow for earlier intervention, leading to better outcomes for youth. Additional funds would be needed to continue and expand this work statewide, which was partially piloted via the Substance Abuse and Mental Health Administration (SAMHSA) Systems of Care grant.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 3</td><td>Potential for High Impact (Score 1-10): 10</td></tr>
<tr><td>• Would require a program change and potentially new services if additional diagnosis codes are approved.
• Cost could be a barrier to implementation.
• Could require a federal approval process, agency budget development and systems to implement.</td><td>• Would benefit a large population.
• Would impact individuals in foster care, low-income individuals, children and those with limited English proficiency.
• Could produce cost savings via reductions in ER visits, pediatrics visits, and use of the criminal justice system and state hospitals.</td></tr>
<tr><td colspan="2">Measuring Impact:
• Percent of Medicaid-eligible children age 0-5 receiving initial trauma and mental health screen within 90 days of entering coverage.
• Utilization of early childhood mental health screening, assessment, and treatment Medicaid codes.</td></tr>
<tr><td>Action Lead: KDHE & KDADS</td><td>Key Collaborators: DCF, MCOs</td></tr>
</table>

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System Transformation Recommendation 9.1: **Regional Model [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Develop a regional model that would supplement the traditional state hospital setting with regionalized facilities accepting both voluntary and involuntary admissions for persons in acute services as well as longer-term/tertiary specialized care. Currently, there is a particular gap in capacity in south central Kansas.</td></tr>
<tr><td colspan="2">Rationale: A version of this recommendation was originally developed by the Mental Health Task Force (MHTF).[39] It was a standalone recommendation in the 2018 MHTF report and then consolidated into Recommendation 1.1 and 1.2 in the 2019 MHTF report. The Working Group discussed that while cost is a primary barrier to implementation, there are opportunities for cost savings by reducing the high cost of transporting individuals to Osawatomie State Hospital (OSH) or Larned State Hospital. Both institutions are a significant distance from key population centers, particularly in the south-central region of the state. This recommendation could be implemented by a combined approach of state institution alternatives (SIAs) and smaller, regional state facilities.

Cost savings accrued via the recommendation could be redirected to the provision of evidence-based services. In addition to cost savings, a reduction in travel would increase safety of the individuals in need of care as well as those in the behavioral health workforce currently providing transportation services, as well as allow individuals to remain closer to local support systems. This recommendation is also seen as a key component to lifting the ongoing moratorium at OSH and is included in the current plan to do so.</td></tr>
<tr><td>Ease of Implementation (Score 1-10): 8</td><td>Potential for High Impact (Score 1-10): 9</td></tr>
<tr><td>• Cost would be a barrier to implementation based on the need for appropriation.</td><td>• Would benefit a large population.
• Could produce cost savings via reduction in transportation costs.</td></tr>
<tr><td colspan="2">Measuring Impact:
• More work is needed to identify measures appropriate to capture the impact of this recommendation.</td></tr>
<tr><td>Action Lead: KDADS</td><td>Key Collaborators: Providers, Local Units of Government, Law Enforcement</td></tr>
</table>

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Telehealth Recommendation 10.2: **Reimbursement Codes [Immediate Action]**

<table>
<tr><td colspan="2">Recommendation: Maintain reimbursement codes added during the public health emergency for tele-behavioral health services and consider options to prevent loss of facility fees so that providers are not losing revenue by delivering telehealth services.</td></tr>
<tr><td colspan="2">Rationale: This is a new recommendation developed by the Telehealth subgroup in consultation with supplemental experts. While many behavioral health services could be provided via telehealth prior to the COVID-19 pandemic, additional codes (e.g., for the SED waiver, crisis intervention, tobacco cessation) have become eligible for reimbursement during the public health emergency (PHE).[44,45,46] Working Group members indicated that some of these services should be maintained after the PHE ends, though the changes were initially intended to be temporary. Additionally, the PHE has led to an expansion of the types of sites where patients can receive care, including at home. Services provided to patients in their homes are not eligible for a facility fee payment for the originating site. In situations where support (e.g., IT support, patient education and preparation) is provided to patients receiving telehealth services in their home, commensurate compensation should be made available to service providers.

Services provided to patients in their homes do not receive a facility fee payment for the originating site, which can contribute to lost revenue for providers, many of whom are having to do additional work (e.g., IT support, patient education and preparation) to provide high-quality services to patients in their home. Consideration should be given to the feasibility of providing additional reimbursement for providers who furnish technical support for patients who receive telehealth services in their homes.

However, further study and consideration should be given to the unintended consequences of mandating payments to providers in excess of in-person mental health visits. The committee would not want to encourage telemedicine in a manner that would incentivize providers to leave their community practices, especially in rural and underserved areas or otherwise reduce their availability for the delivery of in-person care. In addition, if this proposal for additional telemedicine provider payments is applicable beyond the Medicaid program, it likely qualifies as a “provider or benefit” mandate requiring the production of a cost benefit analysis and the “test tracking” of the proposed new charges on the state employees health plan as required by K.S.A. 40-2248 through 40-2249a. [Note: Language submitted during WG report presentation before the Committee.]</td></tr>
<tr><td colspan="2">Measuring Impact:
• Number of telehealth codes open for Medicaid reimbursement pre- and post-pandemic
• Utilization of these telehealth codes</td></tr>
<tr><td>Action Lead: KDHE Division of Healthcare Finance</td><td>Key Collaborators: KDADS, managed care organizations, community mental health centers</td></tr>
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